

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

333

IDPA USE ONLY

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME) <input type="text"/>		2. PATIENT'S DATE OF BIRTH <input type="text"/>	AGE <input type="text"/>	3. INSURED'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME) <input type="text"/>	
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) <input type="text"/>		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. INSURED'S ID AND/OR MEDICARE NO. (INCLUDE ANY LETTERS) <input type="text"/>	
7. PATIENT RELATION TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. INSURED'S GROUP NO. (GROUP NAME) AND/OR MEDICAID NO. <input type="text"/>			
9. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER <input type="text"/>		10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> AUTO <input type="checkbox"/> B. ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) <input type="text"/>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) SIGNED _____ DATE _____				13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW SIGNED (INSURED OR AUTHORIZED PERSON) _____	

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF <input type="text"/>	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) <input type="text"/>	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION <input type="text"/>	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOM: YES <input type="checkbox"/> NO <input type="checkbox"/>	CHECK HERE IF EMERGENCY <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK <input type="text"/>	18. DATES OF TOTAL DISABILITY FROM <input type="text"/> THROUGH <input type="text"/>		DATES OF PARTIAL DISABILITY FROM <input type="text"/> THROUGH <input type="text"/>	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY) <input type="text"/>		PROVIDER NUMBER <input type="text"/>	20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED <input type="text"/> DISCHARGED <input type="text"/>	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE) <input type="text"/>			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES <input type="checkbox"/> NO <input type="checkbox"/>	
23A. HEALTHY KIDS SERVICES YES <input type="checkbox"/> NO <input type="checkbox"/>	23B. FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/>	23C. STERILIZATION/ABORTION YES <input type="checkbox"/> NO <input type="checkbox"/>	23D. PRIOR AUTHORIZATION NUMBER <input type="text"/>	23E. T.O.S. * <input type="checkbox"/>

23F. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

24. REPEAT	A. DATE OF SERVICE	B. P.O.S. *	C. BRIEFLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	DELETE
			PROCEDURE CODE (IDENTIFY)	MOD				
1	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	PRIMARY <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
2	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	SECONDARY <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
3	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
4	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
5	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
6	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
7	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE OF AND IS A PART OF THIS BILL) SIGNED _____ DATE <input type="text"/>			26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY - SEE BACK) YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE <input type="text"/>	28. AMOUNT PAID <input type="text"/>	29. BALANCE DUE <input type="text"/>
32. YOUR PATIENT'S ACCOUNT NUMBER <input type="text"/>			30. YOUR PROVIDER NUMBER <input type="text"/>		31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE <input type="text"/>		
34. NUMBER OF SECTIONS <input type="text"/>			33. YOUR PAYEE NUMBER <input type="text"/>				
35. ORIGINAL DCN <input type="text"/>			36. ORIGINAL VOUCHER NUMBER <input type="text"/>				
37A. TPL CODE <input type="text"/>	37B. TPL STATUS <input type="text"/>	37C. TPL AMOUNT <input type="text"/>	37D. TPL DATE <input type="text"/>	38A. TPL CODE <input type="text"/>	38B. TPL STATUS <input type="text"/>	38C. TPL AMOUNT <input type="text"/>	38D. TPL DATE <input type="text"/>

* PLACE OF SERVICE (P.O.S.) AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS: